411-000-203 Instructions for Completing Form MC-9-NF, "Prior Authorization for Nursing Facility Care"

Use: Form MC-9-NF is used to prior authorize Medicaid payment for nursing facility care. It may be initiated by the nursing facility, Area Agency on Aging or the physician.

Number Prepared: One copy of the four-part form is completed.

Completion: Form MC-9-NF is completed as follows:

SECTION I (Completed by the initiator):

Client Name: Enter the first and last name of the client.

Medicaid Number: Enter the client's 11-digit Nebraska Medicaid number.

Facility Name: Enter the name of the nursing facility or swing bed hospital.

Address: Enter the complete address of the nursing facility or swing bed hospital.
Note: This document is designed to fit into a window envelope; the name and address section will become the "mailing label".

Facility Provider Number: Enter the nursing facility's or swing bed hospital's 11-digit Nebraska Medicaid provider number.

SECTION II (Completed by HHS Central Office staff or the Area Agency on Aging staff):

Level: Enter the two-digit care level for this client (completed by HHS Central Office staff).

Signature/Date: The Program Specialist/RN./Area on Aging staff signs and dates here.

SECTION III (Completed by the physician):

Note: If Form DM-5, "Physician's Confidential Report," is used, attach it to this form and do not complete this section. If Form DM-5 is used, the physician does not complete this section; the initiator (facility) enters the name of the physician, the date on form DM-5, and the physician's license number. If Form DM-5 is not used, attach a current history and physical and complete this section. ("Current" is defined as within 5 days before admission or within 48 hours after admission.)

Diagnoses: Enter the client's diagnoses in the following order:

1. Primary;
2. Secondary; and

3.&4. Tertiary

The physician certifies whether the client is in need of nursing facility care. The physician signs this section and enters his/her license number.

SECTION IV (Complete by HHS Central Office staff):

DX Code: Enter the appropriate ICD-9-CM diagnosis codes according to the diagnoses listed in Section III or on Form DM-5. .

SECTION V (Completed by nursing staff of the facility):

Admission Date: Enter the date the client was admitted to the facility.
Note: The admission date is the date the client was admitted for the current admission, regardless of payment source.

Medication/Special Treatments: Enter the names of medications and special treatments the client receives. If additional space is needed, attach a separate sheet of paper. Computerized medication and treatment sheets may be used.

Medicare Coverage: Enter the dates (from and to) for which Medicare covered the nursing facility care (first and last Medicare covered day).

Discharge: If the resident has been discharged, enter the discharge date.

Signature: The nursing facility staff person who completes this section signs and dates this section.

SECTION VI (Completed by HHS Central Office staff):

Eligibility Determination Date: Enter the date on which the client's eligibility was determined.

Medical Effective Date: Enter the date on which the client's Medicaid eligibility begins.

Long Term Care Insurance: Check the appropriate box. If yes, enter the name of the insurance company and the policy number.

To Date: If Medicaid payment ends before the date of discharge, enter the date that Medicaid payment ends.

Medicaid Payment Effective Date: Enter the date that Medicaid payment to the nursing facility begins. Note: Do NOT include Medicare coinsurance days.

Signature: The local office worker's name and local office name is entered by Central Office staff.

Distribution: The initiator sends the entire form with all attachments to the HHS Central Office. HHS Central Office staff returns the local office and facility copies.

Adjustments: Adjustments to the prior authorization record are made on Form MC-10. See 471-000-211 for instructions.

Nebraska Department of Health and Human Service

Prior Authorization for Nursing Facility Care

This authorization is void if client is ineligible

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

SECTION I

Client Name: _____

Medicaid Number: _____

Facility Name _____

Address _____

_____

Facility Provider Number: _____

SECTION II: CENTRAL OFFICE USE ONLY

From the information below, I certify that this client meets criteria for nursing facility care under the Nebraska Medicaid Program at:

Level _____ **Signature** _____ **Date** _____

SECTION III: PHYSICIAN COMPLETES THIS SECTION

NOTE: If form DM-5 is used, attach it to this form, and complete only license number box in this section. If DM-5 is not used, attach current (within 30 days) history and physical, and complete this entire section:

Diagnoses: 1._____ 2._____

3._____ 4._____

CERTIFICATION OF NEED FOR CARE: I certify the above-named client is in need of nursing facility care at the time of admission and that nursing facility services continue to be needed. ❑ Yes ❑ No

M.D. Signature_____ M.D. License No. _____ (required)

SECTION IV: CENTRAL OFFICE USE ONLY

DX Code: 1. _____ **2.** _____ **3.** _____

MR Diagnosis

SECTION V: FACILITY STAFF COMPLETES THIS SECTION

Admission Date _____

Attachments:_____Medications/special treatments
_____Current history and physical
_____Identification Screen

Medicare - coverage (if applicable), from _____ to _____ (last date of Medicare coverage).

Signature_____ Discharge Date_____

_____

SECTION VI: CENTRAL OFFICE COMPLETES THIS SECTION

Eligibility Determination Date_____ Medical Effective Date_____ **To:**

Long Term Care Insurance ❑ Yes ❑ No - Long Term Care Insurance Company _____

Policy Number _____ Medicaid Payment Effective Date _____

Name of Caseworker_____ Local Office _____